TESTIMONY COVER SHEET

FOR

Daniel Hawkins

Vice-President – Federal, State & Public Affairs
National Association of Community Health Centers, Inc.

Testifying on behalf of the

National Association of Community Health Centers

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Before the House Energy & Commerce
Subcommittee on Oversight & Investigations

On May 25, 2005

Summary:
The Health Centers program has a 40 year record of success that can serve as a model of primary care delivery for the country. Today, all health centers serve an estimated 15 million people in every state and territory, including 6 million uninsured individuals. Health Centers are funded through a combination of patient revenues, federal grants and a variety of state and local funding.

Since Fiscal Year 1998, Congress has increased funding for the Health Centers program more than in any time in its history. The responding growth has allowed more than 7 million additional people to be served. However, with more than 55 million people living in underserved areas of the country, more still needs to be done to address the lack of access to primary care. NACHC is doing all that it can to help health centers succeed and enable communities to take advantage of this historic growth.

The core elements of the Health Centers program are the four pillars outlined in the statute: 1) located in designated Medically-Underserved Areas; 2) open to all, regardless of ability to pay; 3) comprehensive primary care services; and 4) governance by a community board, a majority of whom must be active patients of the Center. The program is authorized through September 30, 2006.

The largest source of revenue for Health Centers nationwide is the payments received for patient care under the Medicaid program. More than 35 percent of patients, and 35 percent of revenue is derived from Medicaid. In 1999, Congress enacted a Prospective Payment System (PPS) for Health Centers which ensures that payments for Medicaid patients do not undermine the financial stability of the Center.

Testimony of

Daniel R. Hawkins, Jr.

Vice President, Federal, State, and Public Affairs

National Association of Community Health Centers

Before the

House Energy and Commerce Subcommittee on Oversight

May 25, 2005

Mr. Chairman and Members of the Subcommittee, my name is Dan Hawkins and I am Vice President for Federal, State, and Public Affairs for the National Association of Community Health Centers. On behalf of America's Health Centers and the 15 million patients they serve, I want to express my gratitude for the opportunity to speak to you today about the federal Health Centers program. NACHC and health centers appreciate the unwavering support that this Subcommittee and the entire Committee has given to carry out their mission and we look forward to continuing to work with you to further strengthen the program to serve medically underserved communities. As the Committee that oversees not just the authorization of the Health Centers program, but also the entire Medicaid program, we appreciate the opportunity to appear before you today.

Mr. Chairman, I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. As a VISTA volunteer assigned to south Texas in the 1960s, the residents of our town asked me to work on improving access to health care and clean water in our community. We decided to apply for funds through a relatively new, innovative program – the Migrant Health program. I stayed on and served as executive director of the health center from 1971 to 1977. The health center is still in operation today, and has expanded to serve over 40,000 patients annually. The community empowerment and patient-directed care model thrives today in every health center in America and I am honored to be here to share with you their success story.

Background and History of the Health Centers Program

Conceived in 1965 as a bold, new experiment in the delivery of health care services to our nation's most vulnerable populations, the Health Centers program has a 40-year record of success that serves as an endearing model of primary care delivery for the country. The Health Centers program began in rural Mississippi, and in inner-city Boston in the mid- 1960s, to serve rural, migrant, and urban individuals who had little access to health care and no voice in the delivery of health services. In the 1980s and 1990s, the Health Care for the Homeless and Public Housing health centers were created. In 1996, the Community, Migrant, Public Housing and Health Care for the Homeless programs were consolidated into a single statutory authority within the Public Health Service Act (PHSA).

Congress established the program as a unique public-private partnership, and has continued to provide direct funding to community organizations for the development and operation of health systems that address pressing local health needs and meet national performance standards. This federal commitment has had a lasting and profound affect on health centers and the communities and patients they serve in every corner of the country. Now, as in 1965, health centers are designed to empower communities to create locally-tailored solutions that improve access to care and the health of the patients they serve.

This blueprint has stood the test of time, and has allowed health centers to serve hundreds of millions of people since the inception of the program. Health centers proudly accept this responsibility in return for the investment made by the American taxpayers in the form of PHSA grants. However, this overwhelmingly poor, uninsured, and medically underserved patient mix creates unique challenges for health centers that are not necessarily confronted by other health care providers.

Current Statistics

Indeed, America's Health Centers serve an estimated 15 million people in every state and territory. Health centers provide care to 10 million people of color, 6 million uninsured individuals, 700,000 seasonal and migrant farmworkers, and 600,000 homeless individuals. Over 1,000 health centers are located in 3,600 rural, frontier, and urban communities across the

country. The communities served by health centers are in dire need of improved access to care, and in many cases the centers serve as the sole provider of health services in the area, including medical, dental, mental health, and substance abuse services.

Patients can walk through the doors of their local health center and receive one-stop health care delivery that offers a broad range of preventive and primary care services, including prenatal and well-child care, immunizations, disease screenings, treatment for chronic diseases such as diabetes, asthma, and hypertension, HIV testing, counseling and treatment, and access to mental health and substance abuse treatment. Health centers also offer critically important enabling services that ensure that health center patients can truly access care, such as family and community outreach, case management, translation and interpretation, and transportation services.

Delivery of High-Quality, Cost-Effective Care

Because of the unique model of patient empowerment, what we like to call "patient democracies", health centers have produced improved health outcomes and quality of life. Health centers provide preventive services to vulnerable populations that may not otherwise have access to certain services such as immunizations, health education, mammograms, and Pap smears, as well as colorectal, glaucoma, and other screenings. Health centers have also made significant headway in preventing anemia and lead poisoning.

Additionally, health centers have distinguished themselves in the management of chronic illness, meeting or exceeding nationally accepted practice standards for treatment of these conditions. In fact, the Institute of Medicine and the General Accounting Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as cardiovascular disease, diabetes, asthma, depression, cancer, and HIV/AIDS.

HHS' Health Resources and Services Administration (HRSA) has also helped improve the provision of quality care at health centers through the Health Disparities Collaboratives initiative. At the end of 2004, more than two-thirds of all health centers had initiated this effort, and an additional 150 health centers have started a Collaborative this year. I like to think of the

Collaboratives as clinical demonstrations for health centers, designed to improve the skills of clinical staff, and strengthen caregiving through the development of extensive patient registries that improve clinicians' ability to monitor the health of individual patients, and effectively educate patients on the self-management of their conditions. More than 75,000 people with chronic diseases have been enrolled in elective registries for cancer, diabetes, asthma, and cardiovascular disease. Health centers participating in the Collaboratives almost unanimously report that health outcomes for their patients have dramatically improved.

As a result of health centers' focus on the provision of preventive and primary care services and management of chronic diseases, low-income, uninsured health center users are more likely to have a usual source of care than the uninsured nationally. 99% of surveyed health center patients report that they were satisfied with the care they receive at health centers. Communities served by health centers have infant mortality rates between 10 and 40% lower than communities not served by health centers, and the latest studies have shown a continued decrease in infant mortality at health centers while the nationwide rate has increased. Health centers are also linked to improvements in accessing early prenatal care and reductions in low birth weight.

This one-stop, patient-centered approach works. The Health Centers program has been recognized by the Office of Management and Budget as one of the most effective and efficiently run programs in the Department of Health and Human Services (HHS). Numerous studies have also pointed to the success of health centers in reducing health disparities and improving the health status of vulnerable populations who receive care at their sites. Indeed, a major report by the George Washington University found that high levels of health center penetration among low-income populations generally results in the narrowing or elimination of health disparities in communities of color.

Historic Expansion of Access Through the Health Centers program

While health centers have had four decades of success, there has been no brighter moment in the life of the program than now. NACHC and health centers are deeply grateful to Congress for its support of the Health Centers program. In Fiscal Year (FY) 2005, Congress appropriated $1.7

billion in overall funding for the Health Centers program, a $566 million increase in funding over FY 2002.

These increases have enabled hundreds of additional communities to participate in the Health Centers program and to deliver community-based care to more than 4 million people in the past 4 years. We are also very grateful that Congress has provided additional funding for base grant adjustments for existing health centers, which have seen unexpected increases in the number of uninsured patients coming through their doors at the very same time they continue to battle the continuously rising cost of delivering health care in their communities. These base grant adjustments have allowed health centers across the country to stabilize their operations and continue to provide care to their existing patients, while also looking for ways to expand access to necessary care.

We also appreciate the President's strong support for the program and his historic request for a $304 million increase in FY 2006, which would bring overall health center funding to $2 billion. This year we expect health centers to serve nearly 16 million people in every state across the country. This would be a tremendous boost for those lacking care in their communities and we wholeheartedly support the Administration's request, which would meet the 5-year goal of the President to serve an additional 6.1 million patients at 1,200 new health centers.

Despite the expansion of the program, the demand for health centers is at record highs – in 2004, we estimate that there were over 430 applications for new access points, only 91 of which received funding – a 21 percent success rate, making health centers' funding on the same level with other competitively awarded grant programs under HHS. Indeed the application process is rigorous, and it should be. Health center program funds are awarded on a nationally competitive basis, ensuring that the highest possible quality projects receive approval. Organizations can apply for new access point funding (which is for new starts and new sites), or for expanded medical capacity funding to serve additional patients at existing sites, or to make new services such as dental or mental health services available to patients.

Given the increasing need for health centers, we are extremely grateful that the President has committed to continue the growth of program by announcing a continuation of his Health Center Initiative into the future. This new announcement will focus on placing new health centers in poor counties that currently lack a health center site, a very ambitious goal. To begin this effort, the President has requested $26 million in FY 2006 to fund 40 new access points in high need counties.

Given the President's new initiative, we have also examined the need in poor counties. NACHC and the George Washington University estimate that there are approximately 929 poor counties in need of a health center, from Kentucky to Michigan. Through this continued expansion, we believe that millions of additional patients would have access to care at a health centers. We commend the President for his continued support of the Health Centers program and we look forward to working with Congress to ensure it reaches every community in need.

Authorization of the Health Centers program

As we look forward in the life of this 40-year experiment in community health empowerment, I note that the Health Centers program was last reauthorized in 2002, as a part of the Health Care Safety Net Amendments Act. The program is scheduled for reauthorization next year. Health centers are grateful to the Committee for its leadership role in strengthening and improving the Section 330 statute in 2002, further modernizing it to serve millions of new patients. Most importantly, in reauthorizing the program the Committee and Congress reaffirmed its four core elements, as it has consistently over the entire life of the program. These core elements, which have greatly contributed to its continued success, require that health centers: 1) be governed by community boards a majority of whose members are current health center patients, to assure responsiveness to local needs; 2) be open to everyone in the communities they serve, regardless of health status, insurance coverage, or ability to pay; 3) be located in high-need medically-underserved areas; and 4) provide comprehensive preventive and primary health care services.

In reauthorizing these bedrock requirements, Congress sent a clear message that it sees patient involvement in health care service delivery as key to health centers' success in providing access and knocking down barriers to health care. Active patient management of health centers assures

responsiveness to local needs. This begins with community empowerment, through the patient-majority governing board that manages health center operations and makes decisions on services provided, and leads to the fulfillment of the other core elements of the program.

Through the direction and input of these community boards, health centers can identify their communities' most pressing health concerns and work with their patients, providers, and other key stakeholders to address these issues. This has been particularly valuable as health centers address and work to eliminate health disparities in their patient population. Board members with unique and direct community connections determine the best approach for removing barriers to health care, helping health centers to meet their patients where they are, not where they want them to be. The critical, distinguishing feature of the health center model of community empowerment is that the community has been directly involved in virtually every aspect of the centers' operations, and, in turn, each health center has become an integral part of its community, identifying the most pressing community needs and either developing or advocating for the most effective business or public policy solutions.

I also want to expand on the other core features of the Section 330 program, each of which has played a key role in the continued success of the Health Centers program. First, health centers are unique among health providers and systems in its statutory requirement that they be open to all in the community regardless of ability to pay. Like the community board requirement, this element is what links health centers the local neighborhoods they serve. There is no cherry picking at health centers; everyone – the uninsured, underinsured, those on Medicaid and Medicare, and those who have private coverage can receive quality health care at health centers. Consequently, health centers have a very diverse payor mix, in which the federal grant constitutes approximately 25% of center revenues. Medicaid and SCHIP make up 40% of revenue, private insurance constitutes 15%, and Medicare approximately 6%. Health centers are interested in addressing health needs on a truly community-wide basis, and the requirement that they be open to all in the areas they serve allows them to do just that.

Second, health centers are required under the statute to be located in high-need, medically-underserved areas. In reauthorizing the provision in 2002, Congress sought to ensure that much-

needed, precious resources are allocated to the communities most in need of the services of a health center. Location of health centers in MUAs prevents the duplication of services, and establishes health centers in newly identified communities or expands the work of existing centers where there are well-documented gaps in care.

Third, health centers are distinctive in the broad range of required and optional primary and preventive health and related services they provide under Section 330. This also includes a range of enabling services that ensure optimal access to care. In 2002, Congress not only reauthorized this requirement, but added to the list by including appropriate cancer screenings and specialty referrals as required services and behavioral health, mental health, substance abuse, and recuperative care treatment as optional services that health centers may provide.

We believe that these core statutory requirements provide the crucial framework for success of the Health Centers program. The program simply would not be where it is today without these critical elements, and we commend Congress for safeguarding these requirements in every reauthorization of the Section 330 since its inception.

Need for Construction Assistance

While health centers greatly appreciate the ongoing effort of the federal government to expand the reach of the program, we must acknowledge the growing need for support for facility construction, renovation, and modernization. Currently, we estimate that over two-thirds of health centers need to upgrade, expand, or replace their facilities. Approximately 30% of health center buildings are more than 30 years old and 65% operate in facilities that are more than 10 years old. The average cost of a facility project is estimated to be $1.8 million, but projects can range in size from a small $400,000 project to a major $20 million effort. NACHC estimates that the current unmet need among health centers for capital projects is approximately $1.2 billion.

We strongly believe that the delivery of quality care to patients at health centers hinges greatly upon the quality of the facilities where care is provided. Prior to 1996, health centers could use a small portion of their grant funding for construction, renovation, and modernization of their

facilities; elimination of this authority during the 1996 reauthorization and the failure to restore it during the 2002 process has severely undermined health centers' ability to successfully address their most pressing capital needs. As just one example, wiring a health center for high-speed IT systems or secure wireless networks, which will be crucial as we move to electronic health records, is not an allowable grant cost today.

Given this limited access to capital resources, health centers were very pleased that the Bureau of Primary Care Loan Guarantee Program was revised as part of the 2002 reauthorization to allow health centers to use loans not only for the development of managed care networks, but also for the purchase of equipment and to refinance existing loans previously made for facility construction. However, these funds still cannot be used for capital projects, and the guarantee covers only 80% of the value of the loan. Consequently, health centers participation has been limited, as many centers find it difficult to cover 20% of initial loan value, because of very slim financial margins as non-profit organizations serving low-income, underserved populations.

Despite this, health centers have worked hard to leverage resources to participate in other federal programs that offer capital assistance. Health centers in rural areas have been very successful in obtaining funding for facility improvement from the Department of Agriculture's Rural Housing Administration programs, which provide loan guarantees up to 90% of loan value. Health centers have had more limited success in accessing facility assistance through the Department of Housing and Urban Development (HUD) programs. If health centers were able to access HUD's loan guarantee and mortgage insurance, they would have an important tool with which to address facility concerns. We look forward to working with Congress to ensure that health centers are given the tools to expand, modernize and, when needed, to build new facilities in order to serve additional patients.

Above all, we stand ready to assist the Committee as you move forward next year to reauthorize the Section 330 Health Centers program and its core elements.

The Importance of Health Centers and Medicaid

I want to turn for a moment to the importance of Medicaid to the Health Centers program. Since their creation back in 1965, Medicaid and health centers have enjoyed a special relationship, as twin pillars of a broad strategy whose goal was to dramatically improve health care for poor, minority, and underserved Americans. Today, that unique relationship continues: just as health centers rely on Medicaid revenues, Medicaid beneficiaries rely on health centers for their care. Health centers are major providers of primary and preventive care services in Medicaid today, caring for nearly six million Medicaid recipients. In fact, Medicaid is currently the single largest beneficiary of health center services, as well as health centers' single largest source of financing. Keenly recognizing the importance of health center services to Medicaid beneficiaries, Congress in the Omnibus Budget Reconciliation Act of 1989 made the services of a Federally Qualified Health Centers (FQHCs) a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program. Most important, Congress recognized and acknowledged that Medicaid reimbursement to FQHCs must be sufficient to assure that health centers were paid their full reasonable costs for serving Medicaid patients (so that they would not have to use their Public Health Service Act grant funds to subsidize low Medicaid payments). In the accompanying Committee report, lawmakers wrote:

"The Subcommittee on Health and the Environment heard testimony that, on average, Medicaid payments to Federally-qualified health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients. The role of the programs funded under sections 329, 330, and 340 of the PHS Act is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever." (U.S. Congress, 1989, p. 415).

In the 16 years since enactment of the FQHC Medicaid requirement, health centers have increased their capacity for uninsured care by 3 million people – double the number of uninsured patients served in 1990, a rate of growth that is more than twice that for the nation's uninsured population. Alternatively stated, the Congress has received a higher rate of return on its annual

appropriations investment in health centers because Medicaid cost-based reimbursement was in place.

In 2000, under the leadership of former Republican Congressman (now Senator) Richard Burr and his Democratic colleague Congressman Edolphus Towns, and with the support of the overwhelming majority of the Energy and Commerce Committee, Congress reaffirmed the continued importance of adequate Medicaid reimbursement to health centers by creating a prospective payment system for FQHCs that (1) assures continued access to care for Medicaid patients, (2) protects Federal grant funds to provide care for the uninsured, and (3) gives state Medicaid agencies greater flexibility in designing their Medicaid programs and predictability in the cost of payments to health centers.

Today, health centers continue to deliver significant savings to all payers, and especially to Medicaid. They control health care costs by providing primary and preventive services, reducing the need for more costly hospital care down the road. In South Carolina, for example, the state health department analyzed their annual costs for patients who have diabetes as a primary or secondary diagnosis. They found that patients of CareSouth, a health center system that had participated in the Diabetes Collaborative, had annual health costs of $343.00 per patient, while patients of other providers had a cost of $1,600 and specialists had a cost of $1,900. The health center had produced those results by reducing the average blood sugar level of their diabetic patients from 11 to 8 – a 3 point drop (a 1 point decrease translates into a 17% decrease in mortality, an 18% decrease in heart attacks, and a 15% decrease in strokes) (Health Resources and Services Administration, 2003).

In addition, according to another study, communities served by health centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than other medically underserved communities not served by a health center (Epstein, 2001). Another study found that Medicaid beneficiaries who seek care at health centers were 22 percent less likely to be hospitalized for potentially avoidable conditions than beneficiaries who obtained care elsewhere (Falik, 2001) Several other studies have found that health centers save the Medicaid program more than 30 percent in annual spending per beneficiary by successfully managing their patients' care in ways

that reduce the need for, and use of, specialty care referrals and hospital admissions (Braddock, 1994: Duggar, 1994a; Duggar, 1994b; Falik, 2001; Starfield, 1994; Stuart, 1995; Stuart, 1993).

Growing Challenges

Beyond paying its fair share for health center services provided to beneficiaries, Medicaid plays an important role by providing its beneficiaries access to comprehensive services beyond those available at health centers. However, as the health care needs of low-income individuals continue to grow, so do the challenges to health centers in sustaining their ability to provide quality care to Medicaid beneficiaries and other patients.

Undoubtedly, one of the greatest of these challenges is the increasing number of states in the past few years that have sought to limit the scope and the breadth of services provided to enrollees in their state Medicaid programs as well as implementing so-called "cost-containment" measures. Cutbacks in Medicaid eligibility levels or benefits, caps in enrollment, or forgone expansion plans naturally are presenting significant difficulties for health centers. What's more, these actions are occurring at the same time as employers are either shifting more of the rising cost of health insurance onto their workers or to dropping the coverage altogether. As other health care providers have begun cutting back on the uncompensated or charity care they provide, the result is that health centers are serving an ever-increasing number of uninsured individuals who previously were covered under Medicaid or through their employers.

Compounding this challenge is the increasing level of discretion being provided to the states in the operation of their Medicaid programs through HHS' issuance of Section 1115 waivers—under which State Medicaid agencies are permitted to reduce benefits, increase cost sharing requirements, and adjust reimbursement rates. Health centers have already experienced the impact of this increased state flexibility in some fifteen states during the 1990s. In most cases, the ability of health centers to care for both their Medicaid and their uninsured patients during this period was negatively impacted when their Medicaid payments were reduced below the cost of providing care. In many of those states, other providers decided not to participate or limited their care to only a few Medicaid patients, leaving health centers as one of the few remaining sources of primary and preventive care to this population.

While these and other changes in the health care system have put a tremendous strain on the overall Health Centers program, health centers remained committed to providing access to care for everyone that walks through their doors, regardless of their health status, insurance coverage, or ability to pay for services. Put simply, health centers will continue to provide care for those whom other providers cannot or will not serve.

Health Centers and Medicaid Reform

As Congress moves forward on considering ways in which to reform Medicaid, it is critical that it keep in mind the important role health centers play in their communities and the unique relationship between these centers and the Medicaid program. Indeed, as the Kaiser Family Foundation points out, "[t]he fundamental interrelationship between Medicaid and health centers . . . suggests, by extension, that dynamics in one domain are bound to have important impacts in the other." It is therefore imperative that lawmakers working on Medicaid reform consider the impact of any changes in that program on the ability of health centers to fulfill their public policy mission.

All health care providers must seek to cross-subsidize when payments from a third party source are insufficient. However, unlike most physician practices that have paid for indigent care services by cross-subsidies from their commercial payers, health centers do not have a substantial commercially insured patient base from which to draw. Evidence abounds that the traditional response by physicians and other providers to reduced Medicaid or Medicare payments has been to restrict or reduce the number of publicly-insured patients they serve, often accompanied by a reduction in the amount of indigent care they provide as well.

Because of the shortage of commercial payments, health centers have three options if Medicaid, their largest third party payer, does not cover the cost of providing care to its beneficiaries. They can (1) reduce health care services or reduce the number of health care access points, (2) close their doors entirely - likely resulting in communities having little or no access to primary health care services - or (3) cover Medicaid shortfalls with their PHSA grants intended to defray the cost of caring for the uninsured.

Ensuring the adequacy of payments under Medicaid, regrettably, is not a new issue for health centers. It in fact has been an ongoing concern since the 1990s, during which the relationship between health centers and Medicaid experienced significant challenges as a result of the increased use of Section 1115 waivers in many states. In most cases throughout this period, the ability of health centers to care for Medicaid and uninsured patients was severely damaged when Medicaid payments were cut to only a fraction of the cost of providing care. Moreover, in many of those states, other providers refused to participate or limited their care to only a few Medicaid patients, leaving health centers as one of the few remaining sources of primary and preventive care to this population.

One of the states in which health centers were most impacted during this period was Tennessee. In 1998, the certified public accounting firm of Goldstein, Golub, Kessler and Company (GGK) examined the impact of low-Medicaid payments on health centers in the state under the TennCare program. In GGK's study they found that, while the number of TennCare visits to health centers increased, the gap between revenues and costs per TennCare visit widened, resulting in significant revenue losses for health centers.

By 1996, Tennessee's health centers were losing almost $28 per TennCare patient visit. This created an unfunded gap in reimbursement that forced health centers to cover these losses out of their PHS Act grants. The result was a reduction in the number of uninsured persons receiving care at Tennessee's health centers, and the virtual elimination of all "supplemental" services, including health and nutrition education, parenting classes and community outreach – all of which have been proven highly effective in improving the overall health of patients.

Increasingly, health centers today continue face many of the same challenges with 1115 waivers as they did in the 1990s. Originally created to allow states to try innovative health care approaches, many recently approved waivers have instead been used to limit benefits, increase cost sharing, and reduce enrollment. In some cases, Medicaid provider payments have been cut dramatically, causing other providers to severely limit or end their participation in Medicaid, and leaving health centers – whose mandate is to serve everyone regardless of ability to pay – as one of the few remaining sources of primary and preventive care to this population. If states are

permitted to cut Medicaid payments to health centers under these waivers, their ability to care for both Medicaid-covered and uninsured patients would be severely damaged. For these reasons, health centers believe strongly that Medicaid waivers should be approved *only* if they "promote the objectives of" Medicaid, and do not erode the program's ability to provide comprehensive services to beneficiaries.

As Congress begins to consider reforms to Medicaid, it will be important for lawmakers to appreciate the integral role of health centers and other core safety net providers in Medicaid, and ensure that these providers are adequately paid for the reasonable costs of health care they provide to enrollees. We look forward to continuing to work with Congress in these efforts.

The Importance of Ensuring Future Health Centers Success

Health centers have successfully stood the test of time over the past four decades, not only because they are rooted in the communities they serve, but because of their attention to continuous quality improvement and technical assistance. Since 2002, health centers have expanded to serve an additional 4 million people, adding approximately 3,000 clinicians and several thousand other staffers at centers across the country. With hundreds of new health centers, staff and patients, it is imperative that health centers, whether brand new or established, receive the technical assistance and training required to successfully expand to provide high quality care.

NACHC and State and Regional Primary Care Associations (S/R PCAs) remain fully committed to and engaged in technical assistance activities with health centers. We have long recognized that the success of the program – and current and future expansion initiatives - depends on the ability of health centers to carry out the requirements of the statute and program expectations.

While HRSA has restructured the availability of technical assistance through its project officers, and decreased funding available for on-site assistance for many new centers, HRSA has been able to help health centers plan and implement effective expansion strategies through a cooperative agreement with NACHC and grants to S/R PCAs,. NACHC and the PCAs also conduct trainings for health center staff regarding financial management, clinical practice

guidelines, regulatory and legal requirements and consumer board trainings. NACHC also assists communities seeking to apply for new health center funding to meet the federal requirements of the grant.

I am very pleased to report that, over the past few years, NACHC has dramatically increased the frequency and types of education, training and technical assistance it provides. Indeed, since the beginning of the expansion initiative, NACHC has conducted 44 health center grant proposal trainings, some in cooperation with the Bureau of Primary Health Care, PCAs and other organizations, and involving over 3000 individuals interested in starting a health center. In addition to onsite trainings conducted at our two annual conferences, NACHC has also conducted trainings in 12 states. We average 300 technical assistance calls a month. We have also held six onsite orientations for new health centers, and six new start teleconference sessions, providing training for approximately 1100 individuals who are on the staffs and boards of the newly-funded health centers in their communities.

Additionally, NACHC has conducted 35 new health center medical director orientation sessions, providing intensive training to over 1100 medical directors representing 1000 health centers, since 2001. Over this same period of time, our clinical team has also conducted quality management trainings for approximately 720 health centers and their clinicians. NACHC also provides trainings and technical assistance on other key aspects of health center operations, including board governance, financial management, corporate compliance, and strategic business planning. We stand ready to continue our activities in all of these areas to ensure that health centers can build on their record of success over the past 40 years and in this current expansion effort.

Conclusion

Health centers appreciate the unwavering support of Congress for the program over the past four decades. In the past 40 years, health centers have produced a return on the federal investment in the program, by providing access to care and a health care home to millions of patients in medically-underserved communities across the country. Because Congress has continued to reaffirm the core elements of the program; that health centers are open to all, run and controlled

by the community, located in high need medically-underserved areas, and provide comprehensive primary and preventive services, the program has successfully faced challenges posed by our ever-changing health care system. On behalf of health centers across the country, their staffs, and the patients they serve, we stand ready to work with you to ensure that health centers continue to provide a health care home for everyone who needs their care. Thank you once again and I would be happy to entertain questions from the committee.

HOUSE COMMITTEE ON ENERGY & COMMERCE

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Daniel R. Hawkins, Jr.

1. **Are you testifying on behalf of a Federal, State, or Local Government entity?** No

2. **Are you testifying on behalf of an entity other than a Government entity?** Yes

3. **Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 2003:**

   None

4. **Other than yourself, please list what entity or entities you are representing:**

   The National Association of Community Health Centers, Inc.

5. **If your answer to question number 2 is yes, please list any offices or elected positions** held or briefly describe your representational capacity with the entities disclosed in question number 4:

   Vice-President – Federal, State, and Public Affairs

6. **If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships whom you are not representing?** No

7. **If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question 4 since October 1, 1999, which exceed 10% of the entities revenue in the year received, including the source and amount of each grant or contract to be listed:**

FY02	BPHC	-	$6,256,559
FY03	BPHC	-	$5,900,000
FY04	BPHC	-	$5,900,000
FY05	BPHC	-	$6,351,213
	Americorps	-	$3,142,069